Clinical Section

Cardiac Neuroses

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The graduating student, fresh from a number of years of intensive work, overwhelmingly materialistic in conception and very largely taken up with the study of normal and abnormal organismal structure and function, feels that he has at last entered upon a satisfying sort of life in which exact science is to be his guide and aim. Very soon he must admit that something is wrong. Patients may come in agreeable numbers and they have complaints that sound legitimate enough. The histories given are frequently vague and circumstantial with little in the way of directing clues. The physical examination, no matter how carefully carried out, fails to reveal any of the expected abnormalities and laboratory tests of every type, relevant or irrelevant to the case, fail to provide an answer as to why the patient should complain as he does. The reaction of the materialist, such as most of us are, is to immediately suspect the bona fides of the patient and to dismiss him either with an assurance (made strong to compensate for the physician's own uncertainty) that there is nothing whatever wrong, and that a little self forgetfulness would be beneficial or send him on his way with a prescription of little true intrinsic merit, but which, it is hoped, will in some mysterious way submerge the troublesome symptoms. Only too often neither technique works and the patient renews his complaints or goes off to someone else, very likely a quack, still searching for relief for what to him are real difficulties.

Most patients are materialists, even as we are. What they expect to hear is news of some definite organic disease. The assurance that there is none, in the face of his continuing discomfort, is not satisfying. The patient little knows, and too often the physician little knows, that the real explanation is not to be found by this never so close scrutiny of individual organs, nor yet in any particular system of organs, but in a survey of the entire individual in his life setting. He is inseparable from this setting and from friction, deficiencies, etc., in it echoes and reverberations set going in his material body, express themselves as the type of symptoms for which 'rule of thumb' medicine never finds a solution.

This disconcerting group of patients constitute the group known as neurotics—a term frequently adorned with accessory expletives, depending on the temper and vocabulary of their physician. Some have gone so far as to say that 70% of the complaints made by patients to physicians do not depend on demonstrable change of structure or function and are properly considered to rest upon a basis of neurosis. This figure is perhaps too high but it calls attention to a great group of people suffering in this way or that, who, because their difficulties are not understood, very often go on suffering. Few of them are malingerers, and it is scarcely just for us, not knowing the origin and genesis of their troubles, to class them as such.

The complaints made by such patients are manifold. They are often poorly defined in the individual's mind and he is unable to accurately state them. Sometimes they are generalized and in their multiplicity seem to leave no part of the body free. Often enough, they are grouped about a single organ, generally one that, to the lay mind, at least, cannot be disordered without life itself being threatened. Then, their anxiety and fear of impending disablement or death, add further symptoms to the already confusing picture. Neuroses with the symptoms arranged like a galaxy with the heart as its supposed centre, are common, and it is not surprising that they should be. Far back in the early morning of Man's life as a self conscious entity, the knowledge of the importance of Heart integrity for life became known. The average lay man of today knows much more concerning his heart than his primitive brother, but with increasing knowledge, have come increasing watchfulness and apprehension. Syndicated newspaper articles give a sharp point to many a neurotic's vague fears by accurately lining up symptoms, cause and expected result. And there are other psychogenic stimuli:

"(1) The statement of some physician or life insurance examiner that the heart shows some abnormality such as a murmur or irregularity of rhythm, or else the rejection of the applicant for life insurance on the score of some heart disturbance or of 'high blood pressure.' Sometimes it is a mere assumption on the part of the applicant himself that the heart must be diseased because two or three examiners were called in to listen to it. In a person of the appropriate mental composition, the slightest suggestion that the heart is not intact, may be enough to start a whole train of emotional reactions leading up to cardiac symptoms.

(2) The occurrence of some dramatic case of heart disease (perhaps with sudden death) among the relatives or friends of the patient.

(3) The noting of some symptom which calls the attention of the patient to his heart and leads to doubt as to its integrity. This may be a sudden skip, a flutter or a twinge of pain, or may be merely what is regarded as undue palpitation or dyspnoea after some special exertion. Such disturbing symptoms are often first noticed dur-

ing convalescence from an illness, such as an attack of grip, or they may appear as a result of the excessive use of tobacco or coffee.

(4) Some profound and protracted emotional disturbance, such as deep grief or prolonged anxiety in which, however, there is, at first, no element of doubt concerning the state of the heart." (*Connors*).

The psychic reaction to doubt concerning the integrity of the heart seems to be much more violent and profound than is the case with any of the other internal organs. Most people who would accept with considerable equanimity the knowledge that they had some disease of liver, kidneys or lungs, will have their morale sadly shaken by any evidence that the heart is not functioning properly, and—

"Present fears
Are less than horrible imaginings
My thought—
Shakes so my single state of man, that function
Is smothered in surmise."

This group of cases—the Cardiac Neuroses—is no inconsiderable one either from the standpoint of numbers or from that of the mass of distress cause, or the economic loss involved. The general practitioner will see most of them. Some will go voluntarily or be referred to the consulting internist or cardiologist. A few get into the hands of the neuropsychiatrists and, considering their general character, this is probably where they belong. It is likely that the actual number is increasing. People nowadays are led to think more and know more about heart and vascular disease and, in addition, the wear and tear of modern life are proving difficult for large numbers of people.

A moment ago, I mentioned some factors responsible in the etiology of this group of Neuroses. There are others:

For instance, it is very common for apprehensive people to interpret as evidences of cardiac disease, signs or symptoms originating outside the heart entirely. It is a common experience with most of us to hear a patient, generally a female, relate symptoms of what she believes is heart disease, but which are plainly the result of gas in the large bowel, especially in the splenic flexture. Left hypochondriacal pain, seemingly aggravated by exertion, coupled with a feeling of incomplete filling of that side of the chest on inspiration, is enough to arouse fears of grave cardiac disease. Another common origin for belief that such disease exists is myalgia of the intercostal muscles. The dull pain located where most people believe their heart is, is convincing, and soon complimentary symptoms are noted and the picture is complete. Similarly disturbances in nearby organs or even in more distant ones, may originate reflex disorders that readily introduce into the patient's mind the fear of cardiac disease and for the elimination of which a great deal of argument and demonstration may be necessary.

Most of us are dimly aware of the thousands of sensations pouring into the sensorium from the ceaseless organic activity going on within us. We are aware of them in much the same way that we are aware of a clock ticking in the room—we really do not note either until some disturbance of the well established rhythm takes place. There are many people who are overly sensitive to these perfectly normal phenomena, and, the remarkable thing is, that disconcerting and all as this is to these people, it becomes still more disconcerting, as, with their attention focussed on these activities, some slight irregularity actually does occur, or is thought to have occurred. When we are in a state of anxious watchfulness, "every bush becomes a bear" and we are very likely to detect the one thing we fear. And there is no organic activity so likely to be noted, misinterpreted and feared, as cardiac activity.

Then again people are more than ever under the stresses of present day living, subject to the play of emotion. Not for a few moments only, but often for hours and days on end—anxiety, especially, and mankind when wanting to express the physical attributes of such emotions, has always referred them to the precordium. Under a burst of emotion, the heart throbs strongly and perhaps irregularly, with a continuing load of emotion, "the perilous stuff that weighs upon the heart," the throbbing continues perceptibly. To the sensitive neurotic, this becomes undoubted evidence of serious disease.

Imitation will account for a certain number of cases of cardiac neuroses among those whose work and life brings them into contact with actual cardiac cases. Nurses, medical students and physicians are not by any means immune from such developments and often prove decidedly intractable patients.

Fear of disease instilled in childhood is responsible for many a neurosis.

One of the very difficult situations one may meet is that in which the neurosis rests upon a basis of actual heart disease. With this actual pathology as a nucleus, the patient creates around about it a veritable cloud of doubts and fears with their usual functional accompaniments. Not infrequently the physician may himself be responsible for this state of affairs. His designation of the heart as "weak" perhaps more frequently refers, or should refer to his own state of mind, rather than the state of the patient's heart. Through lack of knowledge or lack or decision, he leaves gaps for the patient to fill in and too often this results in an over emphasis of the seriousness of the condition, and a situation of the most patience-trying type, is set going.

Now, what are likely to be the complaints of the patient with a cardiac neurosis? Of one thing we may be assured, and that is that they will be many and varied, consisting not only of those which to the patient indicate cardiac disease, but also of others indicative of his vague but appreciable fears.

Most of these patients, by the time they consult one, are pretty well versed in the symptoms of heart disorder, gleaned from their experiences with other physicians and their perusal of popular medical literature. And the thing that strikes one at once, is the preponderance of symptoms over signs, of the subjective over the objective.

Pain is one of the commonest complaints and one must be prepared to listen to and analyze this with care. Careful history taking is of the greatest assistance in one's attempt to get a clear conception of the pain in order that proper differentiation from true angina may be made. To fail to so distinguish these differing pains, would be a most serious matter. The points to be enquired into are—(1) What brings on the pain?; (2) its location?; (3) its character and duration; (4) radiation; (5) and the patients' reaction to it. Real cardiac pain is induced by exertion, sudden emotion such as anger or heavy eating.

The pain of Cardiac Neuroses is not so closely related to these things, although it is true that activity which is distasteful to the patient, may bring it on. True angina is substernal and is not rather indefinitely located where the heart is supposed by the patient to be, as is the case in the neurotic. In the latter, the heavy, squeezing or crushing character of true angina, is not described. Nor is the well known radiation to arm, neck or abdomen mentioned unless the patient has been enlightened by reading or medical interviews. Neurotic pain is longer in duration. He who complains of it shows little evidence of apprehension in his face, no evident tendency to diminished activity and in its description volubility instead of the direct and brief remarks of the true sufferer from angina is noteworthy.

Shortness of breath is commonly complained of by the patients we are discussing. It is rarely the rapid panting respiration of the patient with decompensation, but rather a feeling of inadequate depth to the breathing. They frequently feel that the shortness of breath induced by exertion is too easily induced, but since most of them are softened by relatively low activity, this difficulty is really no more than one would expect.

Undue awareness of heart action is frequently mentioned. Such palpitation is most often noted at night when everything is quiet and there is nothing to divert the patient's attention from himself. Irregularities of rhythm at times occur and change of posture or emotional disturbance such as attention plus apprehension, will increase the rate. Should an extrasystole occur, as often enough happens and without serious significance in people of middle life, the highly sensitive patient feels assured that his case is one of undoubted heart disease.

Digestive Disturbances are at times annoying, but they frequently are also in true cardiac disease. Excessive gas in the digestive tract is the most common of such complaints. Eructations are frequent and obvious air swallowing is the most frequent cause. Distension of stomach, colon, sigmoid and rectum, cause both discomfort and embarrassment.

Fatigability or tiring after an effort of any sort, mental or physical, is common in some degree in all cases of functional heart disease. These patients find themselves unable to perform certain physical tasks incident to work or play, mostly the former. Other activities of agreeable and diverting character really calling for more exertion, are borne well.

Disturbance of Sleep is another of the frequent complaints of the cardiac neurotic and generally speaking has real foundation in fact. Fear and apprehension are the basis and to this is added, soon enough, the fear of not sleeping. To most of the laity, mental integrity is bound to suffer sooner or later in the person who does not sleep.

Diagnosis

Diagnosis of cardiac neurosis is largely a matter of exclusion constantly rendered difficult by the fact that organic disease and neurosis are not mutually exclusive. The patient with true organic heart disease may have a neurosis centering on his heart and the neurosis, not cardiac in type, may have accompanying organic disease. The outcome of a mistaken diagnosis is bad either way. To diagnose organic disease when a neurosis only is present, lays the patient's life open to serious social and economic deformity. And to do the opposite, may expose him to damage of serious and perhaps fatal degree.

It is almost trite to say that no neurosis must be assumed. An opinion as to its presence must rest upon painstaking exclusion of organic disease by the use of every diagnostic means at the physician's disposal. And even when a sincere attempt to do this is made, mistakes will occur. Incipient coronary disease in young patients may be one of the stumbling blocks. One should be decidedly suspicious that true disease is present, if dyspnoea, not as a complaint but as a sign is present. Cyanosis, carefully distinguished from the fleeting and changeable vasomotor flushings of the neurotic is another sign of importance. The ordinary methods of physical examination will be carefully carried out. Responses to physical and emotional stresses will be noted as these are of particular importance. Observation and re-examination will be a necessity in coming to a decision. The electro cardiograph may be requistioned here also. Toward the final diagnosis of neurosis, all these methods of examination will contribute information of value even though it is of negative type. What are some of the positive factors in favor of the diagnosis of a cardiac neurosis? The family history may yield some of these. Neurotic tendencies among others in the family will suggest the possibility of a similar occurrence in the patient.

In the review of the patient's own life, what might be called stigmata of neurosis may be dis-

covered. He may recount illnesses that, leaving little doubt in the examiner's mind that they were of neurotic character, will suggest the possibility in the present instance. The long written out list of symptoms noted by the patient, or evidence that he has read up on his supposed malady, will put anyone on his guard. The patient's occupation and his reaction to it, his domestic situation, his general interests, his religious attitudes, his sexual life, may yield suggestive information. Imitation may be revealed when one gets the history of some relative or close friend suffering or perhaps dead of some former cardiac disease. Consciously or unconsciously, the patient may relate an almost identical chain of symptoms.

We must recall, too, that a neurosis, cardiac or otherwise, may provide an escape for the patient from a set of responsibilities or a situation that is distressing to him. Or it may be a means of securing attention and sympathy not otherwise forthcoming and yet longed for. The convalescent patient recently emerged from an illness calling for much attention and care, may be reluctant to part with the latter and ensure continuation of it by developing a cardiac or other neurosis. These points, difficult at times to elicit, are worth the effort whenever one suspects such an occurrence. Knowledge of the patient's motives is exceedingly helpful in affecting recovery.

I have already mentioned the necessity for most painstaking physical and other examination, and the need for the exercise of great discretion and discrimination. Cases occur, especially those in which there is a nucleus of organic disease or evidence of former disease, in which final decision may not be arrived at until after repeated re-examination.

The success or failure of treatment may be settled in the first interview. The physician who forgets that his patient brings to him symptoms of what he firmly believes is serious disease, who is impatient and does not listen to the whole story with interest and attention, who begins pooh poohing the patient's beliefs, who neglects, or is plainly careless about a physical examination, who shows the patient in one way or another that he does not understand the problem or is minimizing it without adequate knowledge, loses the patient. These people very often come to one because they have already lost faith in one or more other physicians, and they are watchful for evidences of incredulity, carelessness or impatience in us. They are convinced of the reality of their distress and their longing for confidence in and help from the physician, is readily injured.

It is my own belief that whether or not one believes that real structural pathology is present, one should relieve symptoms, especially pain, as soon as possible, and by whatever means are available, avoiding, of course, the use of such drugs as in susceptible people, may result in the establishment of addiction. We should remember that people as likely to be inefficient in meeting life problems as neurotics are, form excellent material for this very thing.

The manner one should adopt toward the patient once one is sure that the difficulties are due to neurosis, will vary with different patients. For some, especially those of obviously fine physical set up, ridicule, used with discretion, may work well. For the physically inferior person whose generally poor set up is already a source of at least a subconscious sense of inadequacy, ridicule would accomplish nothing but harm. Here, a process of education and enlightenment of the patient as to the real genesis of his complaints, coupled with explanation of the baleful effects of introspection, watchfulness and mistaken interpretation, will do much. One must also attempt to show them that physical exertion, far from having serious effects, may even be pleasant. It will do something, often a great deal to displace the deformed neurotic outlook. Even those with a none too good family background can at times be appealed to, to avoid the mistakes of their relatives.

To suggest to the neurotic that he may be a bit of a malingerer never does any good, generally does harm, in that the patient who feels that his veracity is in question, is impelled to justify himself and the net result is not only an antagonistic attitude, but an increase of complaints. The ultimate complete disappearance of symptoms, the idea of recovery must be constantly kept before the patient. But 'rule of thumb' or standardized methods of approach are to be avoided — nothing is more important than to remember that individualization in investigation and treatment must be the watchword in the treatment of all neuroses. The genesis differs and the attitude of the patients is different. How could treatment be uniform?

One of the great difficulties with the sufferers from cardiac neuroses is to get them to take exercise. They all seem to have firmly fixed in their minds the dangers in circulatory disease from over exercise. Something mild must be urged in the first instance, but, as soon as possible, exercise entailing association with people and having an objective. Mere walking is rarely useful. It is often solitary, and one may walk and yet be very thoroughly gnawed at by one's dissatisfactions, etc. A game involves association with others and there is an objective, something to strive toward.

Adequate rest is a need and one the importance of which it is not necessary to dwell upon. Any tampering with the diet is unnecessary and generally harmful. To have to adhere to a diet that so frequently has no rational basis, can only increase introspection.

The exploration and liquidation of mental conflicts, if such are active in creating the disturbance, is no easy task, and, in many instances, the task will have to be left to the neuropsychiatrist. One aspect of the patient's life that may be investigated circumspectly is the sexual life. Anxiety neuroses with palpitation a prominent symptom, are exceedingly common as a result of

certain methods of limiting the family, notably coitus interruptus.

No one ever died of a cardiac neurosis, but an immense amount of suffering and disability often results. The outlook will depend on the mental type and attitude of the patient, the understanding and guidance of the physician, the degree in which doctor and patient co-operate. Confidence in the physician is of paramount importance. It will come only when he merits it through thoroughness in examination, sympathetic understanding, breadth of knowledge not only of cardiac disease but of human difficulties generally, and last but not least, wisdom in the handling of personalities.

NEWS — NOTES

A meeting of the Southern District Medical Society was held at Carman on July 29th. Dr. H. C. Cunningham, of Carman, presided. Dr. Lennox Bell, of Winnipeg, read a short paper on "Diet in Health and Disease," and Dr. C. W. MacCharles, of Winnipeg, discussed "Uterine Displacements—their Significance and Treatment."

At the meeting of the North Western District Medical Society, held at Shoal Lake on June 19th, Dr. John Hillsman of Winnipeg, spoke on "Burns: Their Pathology and Treatment;" Dr. C. E. Corrigan of Winnipeg, on "Appendectomy without Relief of Symptoms," and Dr. O. Bjornson of Winnipeg, on "Failed Forceps."

The Annual Meeting of the Brandon and District Medical Association was held in Brandon June 20, 1935. Dr. E. W. Spencer of Rivers, was nominated as representative to the Manitoba Medical Association, replacing Dr. T. A. Pincock.

Dr. E. S. Moorhead was the host at a luncheon in the Medical Arts Club on June 29th in honour of H. M. Cassidy, Director of Social Welfare, British Columbia.

SUMMER DIARRHEA IN BABIES

Casec (calcium caseinate), which is almost wholly a combination of protein and calcium, offers a quickly effective method of treating all types of diarrhea, both in bottle-fed and breast-fed infants. For the former, the carbohydrate is temporarily omitted from the 24-hour formula and replaced with 8 level tablespoonfuls of Casec. Within a day or two the diarrhea will usually be arrested, and carbohydrate in the form of Dextri-Maltose may safely be added to the formula and the Casec gradually eliminated. Three to six teaspoonfuls of a thin paste of Casec and water, given before each nursing, is well indicated for loose stools in breast-fed babies. Please send for samples to Mead Johnson & Company, Evansville, Indiana.—Adv.

Editorial and Special Articles

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Executive Meeting

MINUTES of a meeting of the Executive of the Manitoba Medical Association, held in the Assembly Hall of the Medical Arts Building, Wednesday, July 24th, 1935, at 6.30 p.m.

Present.

Dr. G. W. Rogers - - -	Chairman
Dr. F. W. Jackson	Dr. W. E. Campbell
Dr. F. D. McKenty	Dr. W. H. Secord
Dr. J. F. Wood	Dr. W. G. Campbell
Dr. F. A. Benner	Dr. H. O. McDiarmid
Dr. E. D. Hudson	Dr. G. S. Fahrni
Dr. J. C. McMillan	Dr. W. E. R. Coad
Dr. A. T. Mathers	Dr. E. W. Spencer
Dr. M. R. MacCharles	Dr. C. W. Wiebe
Dr. E. S. Moorhead	Dr. C. W. MacCharles

The minutes of the last regular Executive meeting, held on March 7th, together with minutes of a Special Meeting of the Winnipeg Members on May 17th, also a Special Meeting on May 27th, were read by the Secretary, and approved.

Business Arising Out of Minutes.

MEMBERSHIP COMMITTEE: Dr. Jackson advised that the Committee on Membership, which was previously appointed, had held two meetings and suggested that if a list of the City Doctors could be obtained who were receiving Unemployment Relief Cheques for work done, that they could be requested to join the Association. This is to be looked into.

AMENDMENT TO MINUTES: Dr. M. R. MacCharles requested than an amendment to the minutes of meeting held March 7th, Page 0411, should be changed from "the x-ray equipment at present in the City" to read "the x-ray equipment at present in the City Hospitals."

CANCER RELIEF & RESEARCH INSTITUTE: Dr. G. S. Fahrni addressed the meeting and stated that as a representative with Dr. M. R. MacCharles of this Association on the Board of the Cancer Relief & Research Institute, that they desired some definite instructions from this Executive to take to the Cancer Relief Board with respect to a proposed plan of re-organization of that Institute. He asked for some statements or an opinion from Dr. Jackson.

Dr. Jackson addressed the meeting and explained that the Cancer Relief & Research Institute were fast getting into financial difficulties, and that the Minister of Health felt it would be better to have something done while the Institute was in full operation. Dr. Jackson stated that as a suggestion it might be advisable for the Department of Health to take over the radium. Dr. Jackson thought the Minister of Health might write a letter to the Cancer Relief & Research Institute and ask them what plan they had in mind for the future.

Dr. Fahrni then explained the present financial situation of the Cancer Relief & Research Institute and that at present it looked as if the plan for a centralized cancer clinic was not possible. He stated that if the Department of Health were to take over the radium and issue it that the Hospitals would probably have to look after the treatment. In fact one of the big Hospitals were now willing to put in one of the large x-ray machines.

Dr. Rogers questioned how with these facilities would the patients be cared for.

Dr. McKenty then advised that the report of the Advisory Council, of which he was Chairman, copies of which had been forwarded to all members of the Executive with a covering letter, had a direct bearing on Dr. Fahrni's request. He asked if this report could not be discussed, and read various parts of his report to the meeting (copy of which is on file). A lengthy discussion followed by nearly all present.

Dr. McDiarmid felt that radium was not being used by country practitioners, as there was too much delay in getting a supply.

Dr. Wiebe asked if the Cancer Relief & Research Institute was dissolved, was it proposed that the Department of Health would treat cancer.

Dr. McDiarmid then stated that most of the radium used is for City patients, very little was ever sent to the country. Brandon had a supply of their own and if the Department of Health took over the radium perhaps the country cases might be willing to come into Winnipeg, but this would upset the work of private owners of radium.

Dr. Jackson stated the Government had no intention of ever treating Cancer in any form. If the Department took over the radium they would do nothing more than issue it on request.

Dr. F. D. McKenty then raised a point of order and asked if it would not be in order to move the adoption of the report of the Advisory Council before introducing new business concerning the Cancer Relief & Research Institute. It was so ruled. Dr. McKenty then amplified and explained the following report, copies of which had been previously mailed to all members of the Executive, and there followed a general discussion of the report and numerous questions about the details of the document were asked and answered. The report follows.

Report of Advisory Council of the Manitoba Medical Association re. Cancer Relief & Research Institute

PART I.

GENERAL CONSIDERATIONS

The Advisory Council of the Manitoba Medical Association is of the opinion that in any re-organization of the Cancer Relief & Research Institute, the following general rules should be observed.

That a high standard in the treatment of cancer can best be attained by centralizing and specializing its administration subject to the following provisos:

1. That the standard of treatment be set and maintained by a competent body which is representative of the medical profession.

2. That the right to practise conferred by the license be not restricted beyond the need for maintaining such standards.

PART II.

SUPPLEMENTARY STUDY OF ACT

The Cancer Relief & Research Institute was set up in this Province on April 14th, 1930, by the Cancer Relief Act.

Aims of Cancer Relief & Research Institute:—The purpose of this body was to — "take such steps as may be considered advisable for the relief or cure of Cancer in the Province of Manitoba" (s.4.), — by acquiring and making available the facilities for radium treatment (s.4.a&b.), through the establishment of clinics for diagnosis and treatment (s.4.c.), through education of the Public (s.4.dc&f.), and — by "adopting such measures as may be deemed requisite for preventing or minimizing the development or spread of the disease" (s.4.d.), — and by voluntarily correlating other similar agencies (s.4.g.). The Institute was also authorized to make through its Board, agreements "with Hospitals, Boards, and establish in conjunction with these, such Institutions or agencies, necessary or incidental to the fulfilment of the objects of the Institute with full power to maintain, operate and carry on the same" (s.5.).

The Trustee Board:—The Institute is governed and managed by a Board of Trustees, consisting of the Minister of Health and others appointed as follows:

University of Manitoba	3	Members
Winnipeg General Hospital	3	"
St. Boniface Hospital	3	"
Manitoba Medical Association	3	"
Winnipeg Medical Society	3	"
Manitoba Hospital Association (from members outside of Winnipeg and St. Boniface)	3	" (S6 C1)
Lieutenant Governor and Council	3	"
Union of Manitoba Municipalities	1	Member Annually

There is further provision under this Section regarding tenure of office vacancies, etc.

Powers of the Board:—To the Board as above constituted is assigned the conduct of the general business of the Institute, and also the direction of its scientific activities. It may — "make by-laws, rules or regulations as to:—

(a) The appointment, functions, duties and removal of all agents, officers and servants of the Institute.

(b) The conduct in all other particulars of the affairs of the Institute" (s.9.).

Committees of the Board:—It is stated in the Act that the Board may delegate any of its powers to Committees of its members. The full text covering this is as follows:—

"The Board may delegate any of its powers to Committees consisting of such members of the Board as the Board may deem advisable. Any Committee so formed shall in the exercise of the powers so delegated conform and be subject to any directions, restrictions and regulations that may from time to time be imposed upon it by the Board" (s.10.).

It is clear from this that any power delegated to a Committee of the Board may be cancelled by the Board as a whole, and apparently the Committee may even be required to submit such report as the Board directs.

Regulations:—Under the regulations already adopted, there appears the following:

"That the use and issue of radium or its emanations should be confined to regularly licensed competent physicians or Institutions who have made a thorough study of its therapeutic value as well as its dangers." (Sec. 15-3.).

The foregoing regulation is quoted in full because it directs attention to the fact that the powers allotted to the Board of the Cancer Relief & Research Institute, authorise it to determine scientific standards for the treatment of cancer within the Province, to decide upon the competence of licensed practitioners to use this agent, and to restrict the facilities for its use to those members of the profession that the Board considers to possess the requisite scientific qualifications. Thus the Board is allotted within its limited field, a medical licensing function.

There already exists a body authorized to determine scientific standards for medicine and to regulate its practice. Through principle and precedent these functions have been entrusted to the Medical Profession as a whole and have been performed by the body established by legal enactment for that purpose, namely, the College of Physicians & Surgeons. The allotment of licensing power to the Cancer Relief & Research Institute as implied in the act of establishment is a marked departure from precedent. The Medical Profession has always opposed the independent licensing of different schools or fields of medicine on the ground that, as there is only one science of medicine, regulation should be vested in one qualified body that can control and co-ordinate its various fields. The establishment of the Cancer Relief & Research Institute as a body independent of the College of Physicians & Surgeons with practical control and licensing power in one field of medicine is incompatible with this claim and inadvertently conflicts with the existing regulations. Some urgent public need is required to justify such an innovation; but it does not appear that the need is urgent enough to forego the gain that would come from revising this anomalous arrangement in such a way as to harmonize it with the Medical Act. The matter is also definitely linked with the serious problem of standardization and regulation of specialties in medicine, it is obviously undesirable that each special branch of medicine should be established as a separate and independent body but such would follow from the present arrangement. The founding of a precedent in this respect calls for careful consideration.

With regard to the composition of the Board of Trustees:—There are some features in the allotment of representation on the Board which should be reconsidered.

(1) Certain hospital institutions, with which the Board is likely to have business transactions, and with which, under the Act, important contracts may be made, are granted the privilege of direct representation on the Board. In the event of such business or contract coming up for consideration, the presence of such representatives may embarass the decisions of the Board. Such arrangement is not in accord with sound administrative practice and its necessity is open to question.

(2) Hospitals can and should be represented effectively through their recognized organization, The Manitoba Hospital Association. Such a provision would avoid the inequity of granting representation to some institutions which is not available to others, which exists with the present Board.

(3) The scientific and regulatory functions of the Cancer Relief & Research Institute should be the responsibility of the College of Physicians & Surgeons. For this purpose it could act through the Medical Faculty of the University, as it does at present in the general medical licensure, and if so authorized could establish a permanent committee whose function would be to advise the Board upon the subjects within its special knowledge. The recommendations of this committee should be matters of record.

The medical and hospital representation on the Board should then be reduced to such membership only as will assure that the scientific and economic interests of those bodies are accurately presented to the Board. For such purpose the following is suggested.

University of Manitoba	3
College of Physicians & Surgeons	1
Medical Faculty	1
Manitoba Medical Association	2
Winnipeg Medical Society	2
Manitoba Hospital Association	6

Exception is to be taken further concerning the inclusion (in Reg. 3.) of Institutions on the same standing as regularly licensed medical practitioners. Institutions, as such, cannot be licensed to practice medicine or be held to attain any specific level of competence in that field.

THE CHANGES DESIRED in the present Cancer Relief & Research Institute are therefore:—

(1) To bring the Institute into proper relation to the Medical Act.

(2) To provide that scientific questions shall be dealt with by a competent body representative of the Medical Profession, and that the recommendations of this body shall be matters of record.

(3) To revise the composition of the Board so as to insure a more equitable representation.

PART III.

SUGGESTED AMENDMENTS

1. That Section 6 be amended as follows: "The members of the Board (other than the Minister of Health and Public Welfare) shall be appointed as follows:—

University of Manitoba	3
College of Physicians & Surgeons	2
Medical Faculty	2
Manitoba Medical Association	3
Manitoba Hospital Association	4

"and the Lieutenant-Governor-in-Council" — remainder of Section 6 unchanged.

2. That there be added to Section 10 the following:—"provided that any committee required to deal with scientific matters shall be free to make such report as it considers correct, and such report shall be entered in the minutes of the Board."

3. That clause (3) of Section 15 be amended to read:—"That the use and issue of radium or its emanations should be confined to those regularly licensed physicians whose competence to use this agent with safety to the public has been approved and certified by the College of Physicians & Surgeons of Manitoba."

Dr. W. H. Secord stated that we had been discussing two separate situations altogether, one was the report of the Advisory Council, which he felt should be adopted, and the other advice to delegates of the Cancer Institute. He maintained that the consideration of the report should be proceeded with and that the affairs of the Institute should be considered in the light of this report of the Advisory Council.

Dr. W. E. Campbell stated that before adopting the report of the Advisory Council he felt an amendment should be made with regard to the representation of members elected to the Cancer Board. It was suggested that this representation be changed as follows:—

University of Manitoba	3
College of Physicians & Surgeons	2
Medical Faculty	2
Manitoba Medical Association	3
Manitoba Hospital Association	4

It was moved by Dr. W. E. Campbell, seconded by Dr. H. O. McDiarmid: That the foregoing amendment be adopted. —Carried.

It was moved by Dr. F. D. McKenty, seconded by Dr. W. H. Secord: That the report of the Advisory Council as amended, be adopted. —Carried.

Dr. J. C. McMillan stated that the Radium Institute was quite willing to supply country practitioners with radium if it was requested, and all they had to do was have their name on the approved list. He felt there was no more delay in getting radium delivered to the country than there would be in obtaining antitoxin, and it could be shipped within twenty-four hours. He stated that, at least, fifty per cent. of the radium used had been for country patients, but the Federal Budget or Winnipeg Foundation would not supply money for treating country indigents.

Dr. Wiebe stated that it would be better if the Department of Health could meet the deficit of the Institute, that their expense might be lower than if they took on the radium, as they would not be able to collect for it.

Dr. Fahrni again addressed the meeting. He felt that the Institute was being misrepresented in previous discussion. The Institute was not a wreck as suggested previously, and was not being turned over as a piece of wreckage. He said it was still an active Institute, and the radium was there, and also the plant. The radium cost $72,000—half in solution and half in salt. Dr. Fahrni stated that it was well known throughout the Province that in the work done during the past four years a greater knowledge than ever before of both the use of the radium and the treatment of cancer, was gained. He stated that there was still a credit of $5,000 in the Institute and they have not gone into liquidation. The Cancer Institute, however, have been carrying the burden for the Department of Health insofar as cancer treatment was concerned. He further stated that Dr. Nicholson had a vast amount of records which had been kept and asked what was going to become of the scientific part of this work. He felt that organized medicine should take the Cancer Institute in hand and do something to keep up the Institute in operation.

Re. King George V. Cancer Fund: It was understood that an amount of $500,000 would be collected by the end of October for this fund. The Dominion Council of Health were asked by the Board of Trustees as to how this fund would be expended. It had been suggested that it will be totally dispensed over a period of ten years, or about $40,000 a year be expended across the Dominion of Canada, Manitoba might get $3,500 a year. It has been recommended, however, that this money be spent for educational work only.

Dr. McDiarmid was opposed to the Department of Health dispersing radium free, and he would like to see the Cancer Committee kept as an Organization.

Dr. Hudson felt the same as Dr. McDiarmid about this. He stated that the work of the Institute had been first-class and was looking forward to the result of the Committee's studies, and did not feel it should be turned over to the Government.

Dr. Jackson stated that the Department of Health were ready to consider favorably whatever the medical profession wanted and all they desired to know what the wishes of the Association were.

Dr. McKenty suggested that a motion be made that the medical members (or the Treatment Committee) of the Cancer Relief & Research Institute discuss this with the Minister of Health and devise some practical scheme and report back to the next Executive Meeting.

Further discussion followed by Dr. McMillan and Dr. Campbell.

It was moved by Dr. J. C. McMillan, seconded by Dr. W. H. Secord: That we instruct our representatives on the Cancer Board that they endeavor to have the Board make some arrangement with the Department of Health for the adequate financing of the Institute, but that the scientific part of the work be the responsibility of organized medicine. —Carried.

Health Exhibition: Mr. Johnson and Mr. Chapman were a delegation desirous of meeting the Executive regarding a Health Exhibition to be held in Winnipeg in October, but it was decided that it was unnecessary to meet these men. The Vice-President was instructed to pick a Committee to get in touch with Mr. Johnson and Mr. Chapman, to go into the matter with them and report back to a further Executive Meeting.

Report of Secretary re. Executive Meeting of Canadian Medical Association held in Atlantic City, June 10-14th, 1935.

Moved by Dr. F. W. Jackson, seconded by Dr. F. D. McKenty: That rather than read the complete report to the meeting, that it be tabled and published in the "Review." —Carried.

The report follows:—

The meeting opened at 10.30 a.m., all members being present. The first item of business was clearing up some odds and ends in reference to the Annual Meeting of the Association, being held during the week at Atlantic City.

Among the items of interest was the consideration of extending an invitation to the American Medical Association to meet in Canada in 1940. This suggestion was incorporated in the resolution at the Executive Meeting, passed on to Council for approval, and the invitation was presented to the American Medical Association.

Discussion also took place at the Executive Meeting as to the advisability of asking the British Medical Association to meet in Canada at the same time. A definite decision as to this was left in abeyance until the American Medical Association signified their intention of accepting the invitation.

Dr. Routley, as Secretary, pointed out that the meeting in Atlantic City was held at the expense of the Association, the American Medical Association taking all the revenue from the commercial exhibits. One would think from the discussion that followed that the Secretary was very wise in allowing such an arrangement to be made, having in mind the joint meeting of the American and British Medical Associations in Canada in 1940, where, no doubt, similar arrangements will be entered into with the American Medical Association; and from a financial standing it appeared to be evident that the Canadian Medical Association would be the gainer.

One of the interesting reports submitted, which was not included in the agenda for Council, was the report in reference to Specialists. A copy of this has already been received by this Association and passed on to the College of Physicians and Surgeons for their comment, and will be considered at the next Executive Meeting.

The Secretary informed the Committee that after a considerable amount of correspondence with the Commissioner of Federal Income Tax, he was successful in having the ten cents a mile rate for operating cars, stand.

Dr. J. S. McEachern had been appointed convener of a Special Committee to report on the Association's ceremonies, and at future meetings of the Association there will now be a definite method of procedure and the Annual Meetings will be resuscitated. This will probably take the form of a Dinner, Speakers and a Dance.

The question of the meeting of the Association for the coming year was also discussed, and it was passed that the meeting be held in Victoria.

Dr. Bazin spoke in reference to the new Constitution and By-Laws and the proposed Constitution and By-Laws were gone into clause by clause by the Executive Committee, and a considerable number of changes made. Your Secretary is of the opinion that these as now drafted, should be entirely satisfactory to this Association. Two of the main changes in connection therewith are (1) the election of the Nominating Committee—this now so reads—that each Province elects a member to the Nominating Committee, and (2) that each Province appoints its own representative on the Executive Committee.

There is also one further standing committee appointed, namely, the Committee on Cancer. The purpose of the appointment of this standing committee is to assist the Board of Trustees of the King George V. Silver Jubilee Campaign Fund in the dispersing of this money if their advice should be asked.

Altogether there were some fifty-one items on the agenda of the Executive, and the meeting was not finished until 7.30 p.m. in the evening.

Your Secretary also had the pleasure of attending the first meeting of the new Executive appointed by the Council in place of Dr. Moorhead, our regular elected representative. This meeting was of only a short duration and routine business only was carried out, consisting of the appointment of Chairmen for the several standing committees.

Your Secretary is pleased to report that the Chairmen of three of these committeee are now located in Manitoba. It seems to be the desire of the Executive to have the Chairmen of the standing committee spread as widely as possible throughout the various Provinces in Canada, and we think that a very good job of this was done.

The meetings were very instructive and your Secretary is of the opinion that if we do not get what we think we should have from the Canadian Medical Association, it is for the simple reason that we do not take enough interest in the activities of the Executive, and do not have any particular subject we may be interested in properly presented to the Executive.

We feel that this condition under the new Constitution and By-Laws will be quite easily remedied, if the various Provincial Associations will use some discretion in the matter of choosing their representative on the Canadian Medical Association Executive, to ensure that someone is appointed who knows the various activities of the Provincial Association and the desires of the profession on a whole.

Annual Meeting: Dr. Jackson reported that the Post Graduate Course had been set for the week commencing Monday, September 9th, and it had been

suggested that on Thursday, September 12th, the Annual Meeting of this Association should be held during the evening and the guest speaker be Dr. T. C. Routley, and Dr. Rogers will give the Presidential Address.

Dr. McMillan advised that the Treasurer, Dr. F. G. McGuinness, felt that it was a mistake to forego the Annual Dinner and Dance.

Following discussion, it was moved by Dr. E. D. Hudson, seconded by Dr. G. S. Fahrni: That we recommend to the Post Graduate Committee that we just have an evening Dinner and Annual Meeting, this to be held on Wednesday, September 11th.
—Carried.

Appointment of Committees - Annual Meeting: Regarding the appointment of Committees to arrange for the Annual Meeting, it was decided to leave this with the present Committee, they being as follows:

Dr. J. C. McMillan
Dr. R. R. Swan
Dr. J. S. McInnes.

Correspondence: A communication was read from Dr. T. C. Routley under date of July 11th, advising resolution that had been passed at the Executive Meeting of the Canadian Medical Association at their Annual Meeting in Atlantic City, asking that the Chairmen of the various Provincial Committees be appointed to Canadian Medical Association Committees.

It was moved by Dr. E. D. Hudson, seconded by Dr. C. W. Wiebe: That the Winnipeg Members of this Executive select chairmen for the Committees as listed by Dr. Routley, at the next meeting held by them. —Carried.

Communication was read from the Manitoba Hospital Association under date of July 16th, asking that a representative of the Manitoba Medical Association be appointed to their Association.

It was moved by Dr. W. E. Campbell, seconded by Dr. F. A. Benner: That Dr. F. D. McKenty be appointed as representative of this Executive to the Manitoba Hospital Association. —Carried.

Communication was read from Dr. H. W. Wadge under date of July 10th, enclosing copy of letter written to Dr. A. W. Moody, Canadian Pacific Railway Surgeon, with reference to a printed form in use by the First-Aid Attendant in their Weston Shops, informing patients to go to a certain Doctor rather than giving them their choice.

Following discussion, it was moved by Dr. F. D. McKenty, seconded by Dr. J. C. McMillan: That a copy of this be forwarded to the Medical Referee Board of the Manitoba Medical Association with instructions to investigate and report at once.
—Carried.

Re. Sociology Committee: In the absence of the Treasurer, Dr. Jackson advised the meeting of the present financial standing of the Sociology Committee, and drew the attention of the meeting to resolution passed by this Executive on April 26th, 1934, whereby Dr. E. S. Moorhead was to receive $250.00 per month salary, and when the funds of the Committee warranted it that this be raised to $300.00 from the commencement.

It was moved by Dr. W. G. Campbell, seconded by Dr. F. A. Benner: That Dr. Moorhead be paid this additional $50.00 per month. —Carried.

Re. Settlement of Medical Accounts on Insurance Claims: Dr. W. G. Campbell addressed the meeting and advised that one or two specific instances had been brought to his attention, whereby insurance claims were being settled by Barristers and that these lawyers had requested the Doctors to cut their accounts in half. He stated that he understood it had been agreed with the Insurance Companies that a Doctor's account would be protected. Dr. Fahrni advised the meeting that he was the Chairman of the Committee previously appointed to deal with this matter, and that this had been definitely understood. Dr. Moorhead suggested that we should advise the Insurance Companies that legislation would be applied for the same as in England, covering this, if accounts could not be protected.

Dr. Jackson stated that the Solicitor for this Association had already prepared an Act governing this, which was shown to the Insurance Companies on previous interviews.

It was moved by Dr. J. C. McMillan, seconded by Dr. F. A. Benner: That these two cases be referred to this Committee on Insurance and that they take it up with the Insurance Companies again, and that this be published in the "Bulletin" so that the Profession throughout the Province may know these facts.
—Carried.

The meeting adjourned.

OBITUARY

THOMAS McCRAE

The passing of Dr. Thomas McCrae removes another landmark of pre-war medicine. He was the eldest son of Lt.-Col. David McCrae and was born in 1870. Lt.-Col. John McCrae (1872-1918), pathologist, physician and poet (*"In Flanders' Fields"*), who died on active service, was his brother. Dr. McCrae was educated at Toronto University and like a number of outstanding graduates from Toronto, went to Johns Hopkins Hospital, Baltimore, and there began that close association with Osler which was to mean so much in the lives of both. McCrae remained at Johns Hopkins as resident, instructor in medicine and associate professor until 1912, when he became professor of medicine of Jefferson Medical College at Philadelphia, a position which he held till his death. He was secretary of the Association of American Physicians from 1917 to 1925, and was president in 1930. In 1924 he delivered the Lumleian lectures at the Royal College of Physicians of London. During the war he was for some time Lt. Col. C.A.M.C. and head of the medical service of a Canadian General hospital.

Dr. McCrae was a literary collaborator with Osler in *"Modern Medicine"* which appeared in seven volumes and went through three editions. In 1916 he took considerable share in the editing of Osler's *"Principles and Practice of Medicine,"* and completely revised the latest edition. He was much interested in the history of medicine and wrote a number of articles. About twelve years ago he visited Winnipeg and held a clinic one morning at the Winnipeg General Hospital. Mr. John Kilgour, a house surgeon at the Winnipeg General Hospital, is a nephew. Another link between Osler and McCrae in addition to the ties of friendship and literary collaboration lay in the fact that Dr. McCrae was married to Sir Wm. Osler's niece, Miss Amy Gwyn, of Dundas, Ont., who survives him.

Department of Health and Public Welfare

NEWS ITEMS

As the Department are continually receiving requests for information relative to Hay Fever, Asthma, etc., we thought the following article, which was written by Doctor W. C. Spain would be timely and of special interest to the rural practitioners:—

MILD AND MASKED ALLERGIC COMPLAINTS: Hay Fever, bronchial asthma, urticaria, and angio-neurotic edema are generally accepted as the chief clinical varieties of allergy and usually are easily recognized. With these obvious forms this discussion is not concerned, but rather with those conditions which are definitely allergic, but are not readily apparent, often being troublesome to identify. There are two chief groups of such vague conditions. The first really comprises the atypical forms of the usually evident allergic complaints just mentioned, the identifying signs being so faint, so indefinite or so intermingled with the symptoms of complicating conditions as to render the allergic features difficult of recognition. The second group contains the allergic varieties of such conditions as eczema, headache, and gastrointestinal disturbances. Here the identification of the allergic status is puzzling since the symptoms are usually indefinite and nonspecific, being frequently shared by other non-hypersensitive complaints.

Clues to the Allergic Nature of These Complaints

Frequently, these vague hypersensitive conditions are linked with the more definite hypersensitive conditions; the history, past or present, of an associated bronchial asthma, hay fever or urticaria, may be the clue which permits the establishment of the more obscure complaint upon an allergic basis. Again, the presence in the family history, collateral or antecedent, of clinical hypersensitiveness is of significance, since it has been definitely established that the tendency to many forms of the hypersensitive state is an inherited, familial, train. The skin tests, scarification or intracutaneous, or in contact dermatitis cases, the patch tests, very often afford conclusive evidence, but in those individuals where the skin reactions prove negative, the allergic basis may be established by studying the clinical symptoms resulting from the test of placing the patient in contact with the suspected cause. In food problems, particularly, "trial and error" or restrictive diets are employed. For convenience these mild or masked allergic forms may be divided arbitrarily into respiratory, gastrointestinal and cutaneous groups which will be considered separately, although often a single patient may possess a variety of these manifestations from a single cause; for instance. coryza, dermatitis, and gastric symptoms may result from a food such as egg, or chocolate, or nuts.

Respiratory Group

Under the designation "acute colds" are hidden mild allergic reactions, many of which are atypical cases of hay fever, or pollinosis, this being particularly true where the characteristic group of symptoms, itching and congestion of the eyes, lacrymation, nasal congestion and discharge, and sneezing, is lacking except for one or two of its members. For instance, hay fever with the one symptom of nasal congestion or of headache, or of inflammation of the eyes alone, may present, particularly where the seasonal limits are ill-defined, some difficulty in diagnosis. A woman of forty suffering each spring with a persistent nasal obstruction, without sneezing, lacrymation or irritation of the eyes was considered as a case of "spring colds" due to "the changeable weather," until the periodicity furnished the clue that led to the diagnosis of tree hay fever, substantiated by means of a positive cutaneous test, to the extract of birch pollen. A young girl of twelve years was seen with a conjunctivitis and episcleritis which occurred each fall soon after the beginning of the school term and lasted several weeks, being attributed to the increased eye strain after the summer vacation. It had not responded to the usual treatments. There were no nasal symptoms. Since the seasonal limits were similar each year, and corresponded to the hay fever period, the case was suspected of being atypical hay fever, which was verified by positive cutaneous tests to ragweed pollen extract.

Attacks of "acute winter colds" are similarly found to be due to the allergic reaction of the respiratory mucosa to air-borne excitants of household origin. These appear in the fall, soon after the individual, usually a child, with added hours indoors after a summer in the open, is subjected to the heated and often parched air of the home with its accumulation of dusts, feather particles, toilet powders, animal danders, etc. Such attacks should be readily identified as allergic, due to the suddenness of their appearance and disappearance, the lack of fever, malaise, and transmissibility, the absence of any mucopurulent or purulent nasal discharge, and the immediate improvement upon change of environment. The cause can be determined usually by cutaneous test, and perhaps, by careful questioning.

These frequently recurring paroxysmal allergic responses readily develop into a persistent form frequently mistaken for a "chronic cold" or "chronic sinusitis." A young woman of thirty had suffered for two years with a persistent serous nasal discharge, unyielding nasal obstruction, sneezing, lacrymation and frequent headaches. Several x-ray films had shown light to be transmitted poorly through all the sinuses. Various nasal operations had aggravated rather than lessened the symptoms. The patient was identified as an allergic case, by following the clue, furnished by herself, that "dry shampoos" (of orris root powder) given at a beauty shop always made the sclera and conjunctiva intensely irritated and edematous. By skin test she was found to be very sensitive to orris root powder, and improved greatly under the allergic treatment indicated. In all individuals with periodically recurring "colds" it is well to consider the possibility of a hypersentitive background before employing catarrhal vaccines, sinus treatments, or other general nonspecific measures. In children particularly, any chronic "cold" or "sinus condition" should be strongly suspected of being basically allergic.

When not treated with specific measures such purely allergic "colds" by their continued presence, frequently lower the local resistance of the individual, and allow the increase of the bacterial flora of the nose and pharynx, thus rendering him susceptible to secondary infections and subsequent complications of the upper and lower respiratory tracts. Thus the activating principle, the allergic factor, though still present may be difficult to identify, being overgrown by the secondary, bacterial invasion with its attendant symptoms. In such cases of long-standing respiratory infection, the results of therapy are often most discouraging even when the allergic factor is recognized and taken into consideration in treatment. This type of case is often associated with chronic bronchial asthma.

In children particularly, foods are frequently responsible for nasal and bronchial symptoms which are difficult to classify as allergic. A child of ten with a history of continued, non-seasonal colds, refractory to all treatments, was otherwise healthy, there being no asthma, bronchitis, eczema or cutaneous symptoms. The one point of significance in the history was that on one occasion an "egg shampoo" had caused violent itching and burning of the scalp and face. Eggs were eaten daily, being apparently well tolerated, with no

evident discomfort resulting. Upon removal of egg from the diet (the skin test to egg was positive) the nasal symptoms immediately and permanently disappeared. A mild persistent cough, without nasal, gastric or cutaneous symptoms, may be due to a food, particularly nuts or chocolate. In other instances, accompanying the nasal discomfort may be pallor, listlessness, fatigue, malnutrition, abdominal discomfort and diarrhea, symptoms of a more profound, gastro-intestinal type of food sensitization.

Gastrointestinal Group

The allergic gastrointestinal forms may be divided according to the reaction time into the immediate type, where the interval between the ingestion of food and the reaction varies between a few seconds and two to three hours, and the delayed type where the interval varies between three hours and several days. In the first, immediate type, the symptoms could never be considered as vague. Indeed, they are so prompt and usually so intense that cause and effect are easily noted by the patient. An example of this allergic form of acute gastroenteritis, is the individual so sensitive to clams that faintness, nausea, vomiting and diarrhea regularly develop within a few moments of ingestion. The cutaneous tests with extracts of the offending foods are usually positive. In addition there may develop symptoms arising from sources other than the gastrointestinal tract, such as asthma, urticaria, and angioneurotic edema.

This immediate type with its usually obvious causes, is mentioned to contrast it with the delayed type less frequently recognized, since more obscure. Here the interval between ingestion and reaction is greater, often two to three days, the symptoms usually being more prolonged, and stubborn. Frequently the symptoms presented are not specific for allergic conditions, as is true in a large group where the chief complaint is "indigestion." Anorexia; coated tongue; bad taste in the mouth; abdominal distress; feeling of fulness or pain in the epigastrium soon after eating; sometimes nausea, eructations of gas and at times of bitter fluids; vomiting, either spontaneous or induced for relief, from a few minutes to two hours after eating—all these are symptoms which certainly point to organic lesions of the stomach, gall-bladder or appendix. They are, however, at times purely functional, and are due to the presence of a food hypersensitiveness. Rarely does the patient apprehend the cause in this condition, since the longer reaction time so confuses the picture that he does not know the food excitant and indeed very often is unaware that a food is responsible. The skin tests should be tried, but usually are of little value in this delayed type. A clue may frequently be obtained, however, by means of a searching clinical history; by ascertaining for instance if there are any abnormalities in the diet; what foods, if any, are eaten to excess, or what foods are eaten though disliked. Restrictive, or "trial and error" diets, are often used to advantage here. A young man of twenty suffering from nausea, coated tongue, eructations and constipation, was found to be drinking two quarts of milk daily, in order to gain weight. His symptoms disappeared, and his weight greatly increased upon total abstinence from milk. A young lady, with similar symptoms, to economize, made her lunch routinely of chocolate bars. All symptoms disappeared upon avoidance of chocolate. In neither case were the skin tests of any aid, being altogether negative. Very frequently in both the immediate and the delayed types of gastrointestinal allergy, cutaneous symptoms are present, caused by the same food excitants by ingestion.

Cutaneous Group

Less well known is the fact that in many instances a food, not by ingestion but by contact alone with the unbroken skin causes cutaneous symptoms. An example of this is the cook who develops a rash soon after handling a raw vegetable, such as white potato. Any variety of food may act in this way. Known particularly as excitants of this type are egg, beef, fish, berries, pineapple, apple, carrots, celery, string beans and asparagus. The symptoms usually are mild, and evanescent, with itching and redness of the face, neck and hands, congestion of the eyes, and sometimes coryza and sneezing. The interval between cause and effect here is usually so brief that the disturbing food is well known to the patient. The symptoms rarely become chronic or severe.

Not only foods, but air-borne excitants, best known as causes of respiratory allergy, by contact, occasionally produce a dermatitis or eczema. Such cases are usually chronic and are so masked that they would be difficult to recognize were it not for the respiratory allergic forms, hay fever, coryza or asthma, with which they are usually associated. Frequently the skin tests are of value. In some excitants of this air-borne type the active principle is an oil, as in the case of ragweed dermatitis, which is seasonal. Contact tests with the oil, obtained from ragweed pollen gives a positive reaction in these cases.

Dyes, drugs and chemicals, by contact, produce allergic dermatoses. Paraphenylendiamin (ursol), an ingredient of many dyes, inks and stains, is particularly irritating. A child of fifteen with a facial "eczema" of six months standing, with periodic exacerbations each Monday was found sensitive to rotogravure ink to which he was exposed when reading the pictorial section of the Sunday newspaper. This was proved by a positive reaction to a contact test with the ink. In a woman of forty, a chronic dermatitis of the eyelids of two years standing, was found by patch test to be due to a hair dye she was using; avoidance of this cleared the condition. Dyes for furs, shoes, and fabrics must be borne in mind as possible causes of dermatoses ranging from a mild acute itching and erythema to a chronic stubborn involvement. Lacquers, wood stains, dry cleaning reagents and petroleum products also must be considered here. The clinical history, and the anatomical location of the lesions often aid in determining the cause in these cases. Contact tests with a small portion of the suspected material usually should be made, and with caution. Hair tonics and lotions, wave set preparations of flaxseed or quinceseed, and other cosmetics, often containing bichloride of mercury, quinine or other chemicals, are known to have been contact irritants in many instances.

Drugs, by ingestion, are of course frequently responsible for acute and chronic rashes. Acetyl-salicylic acid, phenacetin, the salicylates, quinine, antipyrin, pyramidon, mercury, arsenic and the essential oils must be considered as causes. The specific allergic reaction produced in sensitive individuals by these drugs must not be confused with the effect of ordinary overdosage, from which it is quite different.

There are a variety of other, unusual allergic responses which do not fall into the three groups just discussed, such as the occasional cases, proven allergic, of acute urinary bladder disturbance, epileptiform seizures, allergic arthritis and allergic labyrinthitis (with resemblances to Ménière's disease). The majority of such hypersentitive conditions doubtless go unsuspected; indeed, without a significant history, or the presence of known allergy, past or present, in the patient or his family, the probability of proper etiologic classification is very slight. Rendering the situation more difficult, is the fact that the cutaneous test is of little aid in the majority of these cases. With such a paucity of concrete evidence it is no wonder that the borderlines of clinical allergy become hazy and befogged, and that continually the temptation exists to make the diagnoses, in these obsecure conditions, upon mere surmise.

In conclusion it should be emphasized that these mild or masked allergic forms of hay fever, bronchial asthma, urticaria and food disturbances differ from the more obvious chiefly in the difficulties they offer in identification rather than in the problems connected

with treatment. Indeed, when once their allergic nature has been recognized, it becomes apparent that the therapeutic procedures best suited for the typical cases, are equally applicable to these obscure allergic forms.

COMMUNICABLE DISEASES REPORTED
Urban and Rural : June, 1935

Occurring in the Municipalities of:—

Mumps: Total 482—Winnipeg 360, Kildonan East 54, St. Boniface 28, Kildonan West 14, Kildonan North 10, Arthur 2, Fort Garry 2, Miniota 2, Rosser 2, St. Paul West 2, Emerson 1, Ethelbert 1, Kildonan Old 1, Souris 1, St. James 1, Unorganized 1.

Measles: Total 301 — Winnipeg 68, Blanchard 56, Springfield 30, Melita 29, Unorganized 22, Lorne 19, Albert 10, Strathclair 10, Virden 10, Souris 8, Ste. Rose Rural 8, Minitonas 6, Roblin Rural 5, Roland 3, Ste. Rose du Lac 3, Cameron 2, Glenwood 1, Kildonan East 1, Macdonald 1, Pipestone 1, Riverside 1, St. Paul East 1, Thompson 1, Wallace 1. (Late Reported, March: St. Clements 1; April: Lawrence 1, Unorganized 2).

Chickenpox: Total 157—Winnipeg 77, St. Boniface 29, Kildonan West 23, Brandon 7, Unorganized 4, Ste. Rose Rural 3, Virden 3, Strathcona 2, St. Vital 2, Boulton 1, Coldwell 1, Fort Garry 1, Kildonan 1, Lorne 1, St. James 1, Wallace 1.

Whooping Cough: Total 136—Winnipeg 63, Dauphin Town 12, Brandon 12, St. Boniface 10, Ethelbert 9, Arthur 8, Lorne 7, Kildonan East 4, Assiniboia 2, Flin Flon 2, Morton 2, Boissevain 1, Fort Garry 1, St. James 1, St. Vital 1. (Late Reported, April: Tache 1).

Scarlet Fever: Total 76—Winnipeg 17, Unorganized 17, Flin Flon 9, Portage Rural 5, Silver Creek 5, St. Vital 3, Plum Coulee 2, Teulon 2, Coldwell 1, Franklin 1, Grey 1, Kildonan East 1, Minitonas 1, Rhineland 1, Springfield 1, St. Boniface 1, St. Clements 1, The Pas 1, Woodlands 1. (Late Reported, April: St. Paul East 1; May: Unorganized 4).

Tuberculosis: Total 73—Winnipeg 17, Unorganized 4, Rhineland 3, St. Clements 3, Turtle Mountain 3, Kildonan East 2, Rivers 2, Selkirk 2, Sifton 2, Whitemouth 2, Brandon 1, Carman 1, Clanwilliam 1, Cypress North 1, DeSalaberry 1, Dufferin 1, Eriksdale 1, Ethelbert 1, Flin Flon 1, Gimli Rural 1, Glenwood 1, Grandview Town 1, Harrison 1, Hillsburg 1, Kildonan Old 1, Kildonan West 1, Langford 1, Lawrence 1, Macdonald 1, Morden 1, McCreary 1, Portage City 1, Russell Town 1, Saskatchewan 1, Stonewall 1, Swan River Town 1, St. Andrews 1, Ste. Anne 1, St. James 1, St. Laurent 1, Ste. Rose Rural 1, Tuxedo 1, Woodlea 1.

German Measles: Total 49—Unorganized 16, St. Boniface 15, Kildonan West 10, Kildonan Old 4, Strathcona 3, Kildonan East 1.

Diphtheria: Total 29—Morris Rural 10, Winnipeg 9, Dauphin Rural 2, La Broquerie 2, St. Vital 2, Gretna 1, Rhineland 1, Swan River Rural 1, St. Boniface 1.

Influenza: Total 11—Winnipeg 4. (Late Reported, April: Unorganized 2, Brandon 1, Ellice 1, Grandview Rural 1, Minnedosa 1, Winnipegosis 1).

Erysipelas: Total 4—Winnipeg 3, Transcona 1.

Puerperal Fever: Total 2—Winnipeg 1, Ellice 1.

Typhoid Fever: Total 2—Grandview Rural 1, Unorganized 1.

Diphtheria Carriers: Total 2—Winnipeg 2.

Anterior Poliomyelitis: Total 1—Dauphin Rural 1.

Trachoma: Total 1—Unorganized 1.

Venereal Diseases: Total 116—Gonorrhoea 92, Syphilis 24.

DEATHS FROM ALL CAUSES IN MANITOBA
for the Month of May : 1935

URBAN—Cancer 48, Tuberculosis 16, Pneumonia (all forms) 8, Puerperal 4, Influenza 3, Erysipelas 2, Syphilis 2, Typhoid Fever 1, all others under one year 5, all other causes 136, Stillbirths 18. Total 243

RURAL—Cancer 24, Tuberculosis 23, Pneumonia (all forms) 16, Measles 5, Puerperal 3, Influenza 2, Typhoid Fever 1, all others under one year 7, all other causes 154, Stillbirths 18. Total 253

INDIANS — Tuberculosis 10, Pneumonia (all forms) 7, Whooping Cough 6, Measles 2, Influenza 1, all others under one year 1, all other causes 6. Total 33

Medical Library
University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

"The Practitioner"—May, 1935.

"The Advance of Medicine during the last Quarter of a Century"—by Sir Humphrey Rolleston, G.C.V.O., K.C.B.

"The Problem of Allergy"—by R. J. S. McDowall, M.B., D.Sc., F.R.C.P.E.

"The Treatment of Asthma"—by J. L. Livingstone, M.D., F.R.C.P.

"Hay-Fever and its Treatment" — by Clement Francis, M.A., M.B., B.Ch.

"Some Unusual Examples of Allergic Reaction" —by George W. Bray, M.B., M.R.C.P.

"Bacterial Allergy and its Relation to Tuberculosis and Rheumatic Fever"—by W. R. F. Colles, M.A., M.D., F.R.C.P., M.R.C.P.I.

"Allergy in Relation to Diseases of the Skin"—by G. B. Dowling, M.D., F.R.C.P.

"The Vitamins in Health and Disease" — by Adolphe Abrahams, O.B.E., M.D., F.R.C.P.

"Total Thyroidectomy in the Treatment of Heart Disease and Angine Pectoris" — by George Bankoff, M.D., M.S.

"The Treatment of Internal Haemorrhoids"—by J. W. Riddoch, M.C., M.B., Ch.B., F.R.C.S.E.

"The Non-Operative Treatment of Urinary Stone" —by Stephen Power, M.S., F.R.C.S.

"The Clinical Journal"—July, 1935.

"The Surgical Aspects of Diseases of the Colon" —by Harold C. Edwards, M.S., F.R.C.S., Surgeon to Kings College Hospital, London.

"The Failing Heart" — by George E. Ward, Physician, Middlesex Hospital.